Japan Council for Quality Health Care

Project to Collect Medical Near-Miss/
Adverse Event Information

Medical Safety Information

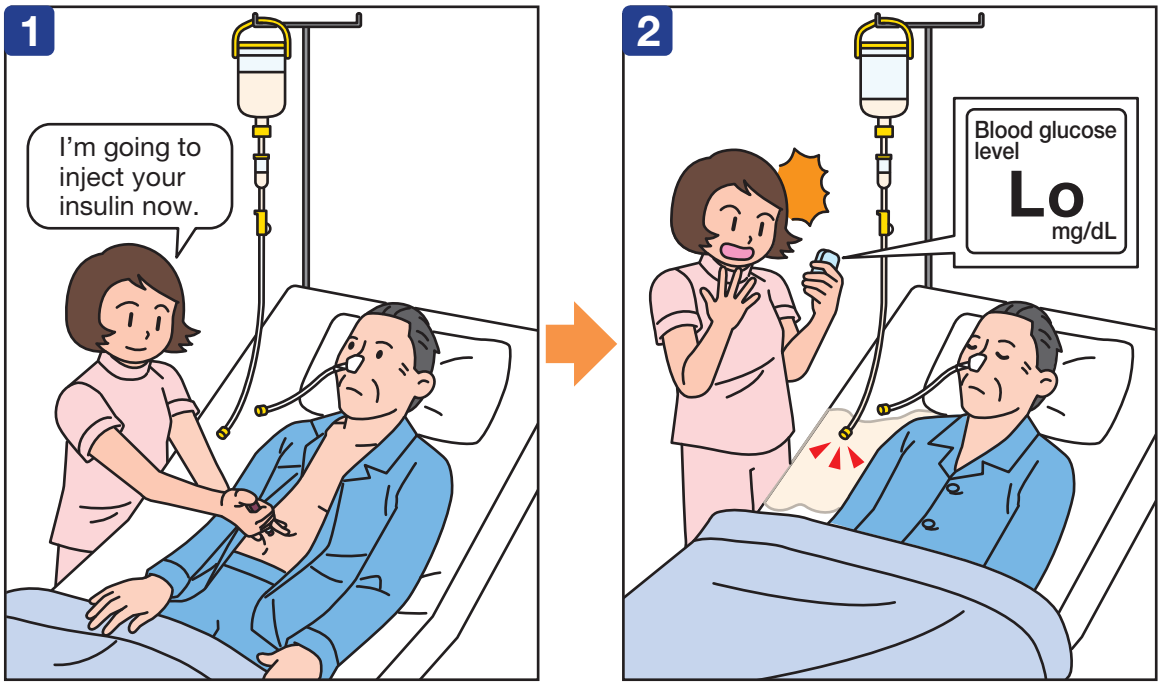
No.174, May 2021

# Failure to Inject Enteral Nutrient after Administering Insulin

Six cases have been reported in which a patient suffered low blood glucose due to medical staff failing to connect an enteral nutrient route or forgetting to start its administration after administering insulin (information collection period: from January 1, 2017 to March 31, 2021). This information was compiled on the basis of the content featured in the Analysis Themes section of the 60th Quarterly Report.

**Cases have been reported in which a patient suffered low blood glucose due to medical staff failing to inject an enteral nutrient after administering insulin.**

Image of case 1



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## Case 1

The nurse started an enteral nutrient drip after administering a subcutaneous injection of 22 units of NovoRapid Injection to the patient. An hour and a half later, having noticed that the enteral nutrient had leaked onto the sheet, the nurse checked the connector and realized that the enteral nutrient route had not been connected to the nasogastric feeding tube. As the patient's blood glucose level had fallen, 20% glucose solution was administered.

## Case 2

Nurse A measured the patient's blood glucose level and Nurse B administered a subcutaneous injection of 10 units of NovoRapid Injection. Nurse A subsequently forgot to inject the enteral nutrient. Three hours later, when the physician did their round, the patient's level of consciousness had declined, so blood tests and a CT examination were carried out. The patient's blood glucose level was 11 mg/dL and the fact that the enteral nutrient had not been injected was discovered, so 20% glucose solution and the enteral nutrient were administered.

### Preventive measures taken at the medical institutions in which the events occurred

- **Check that the enteral nutrient route is connected to the nasogastric feeding tube, etc. before starting the drip.**
- **Nurses will share information with each other regarding the administration of insulin and enteral nutrients to patients.**

The measures above are examples. Please consider initiatives suitable for your own facility.

* As part of the Project to Collect Medical Near-Miss/Adverse Event Information (a Ministry of Health, Labour and Welfare grant project), this medical safety information was prepared based on the cases collected in the Project as well as on opinions of the "Comprehensive Evaluation Panel" to prevent the occurrence and recurrence of medical adverse events. See the Project website for details.
http://www.med-safe.jp/

* Accuracy of information was ensured at the time of preparation but cannot be guaranteed in the future.

* This information is intended neither to limit the discretion of healthcare providers nor to impose certain obligations or responsibilities on them.

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